Patient ID:____________

PLEASE PRINT OUT, COMPLETE, AND BRING TO ANNUAL APPOINTMENT

Patient Name________________________ **Owner Name**______________________ **Date**____________

CANINE

ANNUAL OWNER HISTORY AND RISK FACTOR EVALUATION

For us to evaluate your dog it is very important that you are his or her voice. We'll use this information to evaluate your dog's health and individualize the care your dog receives, including examinations and vaccinations. From the numbers 1-14, put a check next to the sentences that describe your dog's lifestyle.

My dog

1. Mainly stays in yard	( )Yes	( )No
2. Is taken for walks	( )Yes	( )No
3. Is taken to parks	( )Yes	( )No
4. Goes camping	( )Yes	( )No
5. Is taken to groomers	( )Yes	( )No
6. Occasionally goes to PetsMart or PetCo	( )Yes	( )No
7. Is taken to country or farm	( )Yes	( )No
8. Is taken to boarding kennels when we are on vacation	( )Yes	( )No
9. Is taken to outdoor community events	( )Yes	( )No
10. Is taken to community vaccination clinics	( )Yes	( )No
11. Is sometimes visited or visits other dogs	( )Yes	( )No
12. Attends obedience or training classes	( )Yes	( )No
13. Participates in competitive events (i.e. dog shows)	( )Yes	( )No
14. Is used for hunting	( )Yes	( )No

Please answer the following questions to the best of your knowledge:

Appetite	( ) Decreased	( ) Normal	( ) Increased
Weight	( ) Loss	( ) Gain	( ) Stable
Water Consumption	( ) Decreased	( ) Normal	( ) Increased
Bowel Movements	( ) Constipated	( ) Normal	( ) Diarrhea (How long?________)
Urination	( ) Decreased	( ) Normal	( ) Increased Amount
Incontinence (Loss of housetraining)	( )Yes	( )No	( )Increased Frequency

Vomiting	( )Yes	( )No				
Straining to urinate	( )Yes	( )No				
Coughing	( )Yes	( )No				
Sneezing	( )Yes	( )No				
Gagging	( )Yes	( )No				
Any Listlessness	( )Yes	( )No				
Any weakness	( )Yes	( )No				
Shaking Head	( )Yes	( )No				
Scratching	( )Yes	( )No	(Location:_____________)			
Significant Hair Loss	( )Yes	( )No	( )Patchy	( )Generalized	( )Excessive Shedding	
Flea Control Used	( )Yes	( )No	( )Frontline	( )Advantage	( )Revolution	( )Other
Heartworm Control	( )Yes	( )No	( )Heartgard	( )Sentinel	( )Interceptor	( )Other
Scooting	( )Yes	( )No				
Unusual Lumps or Bumps	( )Yes	( )No				
Bad Breath	( )Yes	( )No				
Unusual Discharge	( )Yes	( )No				
Lameness	( )Yes	( )No	(Which leg: ( )RF ( )LF ( )RR ( )LR)			
Difficulty Rising	( )Yes	( )No	Difficulty Climbing Stairs? ( )Yes ( )No			
Any Behavioral Changes	( )Yes	( )No	(Describe:____________)			
Currently on Medications	( )Yes	( )No	(Name:________________)			